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Payment Policy, Quality of Care and Decision Making With Inadequate Information

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The health care system in the United States is in chaos. The conflict is between containing costs on an aggregate level while, at the same time, not reducing services to the individual if the services are essential for quality care. There is little information on which to base decisions about the value of services. Health care organizations and delivery models must be restructured because current models are out of date. To accomplish this restructuring, better information is needed on why hospitals and doctors do what they do. Success in developing information and decision models that result in patients receiving only medically necessary services will contribute greatly to promoting high quality, cost-conscious care.

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The health care delivery and financing system in the United States is undergoing profound change. The system is characterized by instability, turmoil, anger and multiple cracks and flaws. The theme of this discussion is that our organizational, financial and, especially, informational support systems are simply not adequate to cope with the rapid change that is occurring and with the conflicting goals that confront us as we attempt to achieve high quality and cost-conscious care. Three major forces are leading to a change in the system.

Major forces leading to changes in health care delivery. *The first force is a public perception of the need to constrain the rate of increase in health care expenditures.* Employers, labor, government, beneficiary groups and third parties all believe in the need to constrain the rate of increase in health care expenditures. However, they believe that aggregate expenditures need to be constrained. Many of these groups will not accept a reduction in services to individual patients to achieve cost-containment goals.

A second major force consists of new technologic capabilities that, together with changing social values and social beliefs, allow services to be furnished in a host of new settings. These include ambulatory surgical centers, free-standing diagnostic centers, nuclear magnetic resonance imaging centers and free-standing cardiac catheterization centers. In addition, new technologies are available, including infusion pumps and implantable defibrillators being used by patients miles from a hospital, catheterization during acute myocardial infarction, tissue plasminogen activator and balloon valvuloplasty. All of these technologies raise major issues of both cost and quality of care. Of particular concern to me is the quality of care furnished in alternative settings. This is a subject that has received very little attention. We focus much of our time and resources on the hospital, but the emergence of these new alternative settings raises a host of new quality of care concerns that receive little time and attention.

The third force is the belief, at least a transient belief, that a more competitive medical market place will decrease costs and still allow us to have all the necessary individual services that we can consume. Therefore, we see the growth of health maintenance organizations (HMOs), preferred provider organizations (PPOs), and independent practice associations (IPAs); we see providers merging with insurance companies until there is a blur between what is an insurance company and what is a provider.

As the result of these three forces—the public perception that we should contain costs (without reducing services), new technologic capabilities and the belief in the medical market—we are left with extreme turmoil. Purchasers of services, including the government, traditional insurance companies, employers and organizations representing employees, are using their purchasing power in a way they have never used it before. They are using the new technologic capabilities to stimulate competition and control costs. Also, as a result of these forces, the providers of service, including physicians, are increasingly competing with each other on

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JACC Vol. 14, No. 3
September 1989:3A–6A

the basis of cost, technologic capability and quality of care. The purpose of the competition is to gain market share or, as the physicians would prefer to say, more patients, which is market share.

Insurance strategy. The insurance strategy has been to develop policies to share risk. In insurance terms, insurance protects against risk. You have automobile, home and boat insurance. You also have insurance for protection against costly illness. Until 10 years ago, insurance companies, the government, the Blues (Blue Cross and Blue Shield) and the commercial insurers essentially behaved as conduits. They passed on the money from those who paid the premium to those (you) who provided the service. They were truly, in name and in function, third parties. Today, the insurance function has been fragmented. There is still the need to actuarially forecast the risk of illness, but this is quite straightforward. In fact, it is sufficiently well understood today that a major problem is the skimming of low risk individuals and fears of dumping of high risk individuals by both payers and providers.

What is new in the insurance function today is the decision by third parties to use competition to share the risk, not the risk of illness, but the risk of treating the illness—which services are furnished, where they are provided and who furnishes them. Health maintenance organizations have used this approach for many years, but now all third parties are using it. Government, with Medicare's prospective payment system, pays a preset fee for a hospital stay and allows a provider to make a profit or a loss. It is sharing the risk of the treatment during a hospital course of illness. Preferred provider organizations that negotiate for contracts do the same thing. Medicaid with selective contracting policies is simply sharing the risk of treatment, not necessarily the risk of illness.

Role of insurance companies in decision making. Medicare, HMOs and CMPs as well as the Blues and the commercial insurers are all accomplishing this by developing managed care programs. How are they sharing risk, and why is this important to decision making? It is important because the information you generate is frequently targeted to a user group, and these individuals and organizations are very important user groups.

First, the insurance companies use information to create financial incentives to share the risk of loss and allow an opportunity for profit. The Medicare diagnosis-related groups (DRGs), Medicare capitated programs and other managed care initiatives use information to create financial incentives. Prices may be set by the payer as they are with Medicare, prospective payment system (PPS) or businesses may be asked to offer prices for the right to get market share. Providers are then faced with the need to compete with each other for the price that is set or the price they bid in order to survive and hold an adequate market share.

The second major way that groups are using information is by examination of the use of services. Both traditional insurance companies and the new nontraditional managed care entities are engaging in far more active oversight as to how services are furnished, leaving you with a very clear target group for new information. The tools that these groups are using are preadmission review and certification. Who gets into the hospital and who does not? Who gets the service and who does not? Concurrent review of medical records, retrospective review and second opinion programs are in place. By and large, however, all of these tools continue to be directed only to the hospital. They are not directed to the physician, and very frequently are not directed to the new alternative sites of care delivery. As a result, there is a wide gap where services can be shifted out of a hospital with virtually no oversight as to quality care and utilization.

Cost-containment measures and increased competition have not reduced costs. How have DRGs, HMOs, PPOs fared in the move toward cost-containment and more competition? First, we have redistributed dollars. Lengths of stay and admission rates to the hospital for patients insured by Medicare and for all third parties have decreased dramatically. The fraction of our dollars going to inpatient hospital services has dropped, and the fraction going to outpatient hospital services has increased, as has the fraction going to other outpatient services and physicians.

Second, and this may come as a surprise to some of you, we have not altered the historic rate of increase in expenditures for health services in this country. Despite all the hand-wringing, all the press and all the editorials, we have not altered the rate of increase in health care expenditures. Total health care expenditures in this country in 1986 were $458 billion, 10.9% of the gross national product and an increase of 8.4% from 1985. Those are total health care dollars. Let us look only at the direct provision of goods and services to beneficiaries. In 1986, the direct provision of goods and services was $404 billion in this country, an increase of 8.8% from 1985. Cost containment from 1985 to 1986 was an 8.8% increase. Now take that 8.8% and fragment it; it falls into three categories. The first category is price inflation. General medical prices increased from 1985 to 1986 by 7.5%. The rate of inflation in our general economy in that same time frame was only 1.9%. You may argue that 1.9% is distorted because of the significant decrease in oil prices. Prices went up 3.9% in the general economy, not 7.5%. You say that still is not right because the general economy represents manufacturing as well as services. In fact, the service sector economy of 1985 to 1986 went up 5%. Medical price inflation still went up 7.5%, which is 54% of the overall growth. We have more people, more older people, more people getting more services to account for. Of the 8.8% increase, only 11% was accounted for by population growth and aging. Fifty-four percent is due to inflation;

35% of the increase was for changes in consumption and intensity of consumption.

We continue to provide more services to the same people, and more services to new people, so our cost-containment initiative is essentially a national myth. Our rate of increase is almost at the same level that it has been for the past 10 years when you deflate for price. It is projected with the current policies that by the year 2000, some 11 years from now, we will be spending $1.5 trillion on health care, 15% of our gross national product.

Problems with cost containment. Why, then, with the belief in cost containment and all the pressure and hand-wringing are we so concerned about a decrease in quality of care? Do we really know if quality of care has altered? If quality of care is altered, it certainly cannot be because we have altered the total number of dollars that have been put into the system. We have altered the distribution of dollars. Is the perception regarding changes in quality of care merely that? A perception. We simply do not know.

Let me give you some thoughts as to why we have not been able to do any better than we have in cost containment. *First, we do not know how to reduce costs without reducing services, and we do not want to reduce services for fear that quality of care will diminish.* Our information base and decision-making skills are sufficiently poor that in the absence of clear evidence that a procedure is not valuable, we will proceed with it and pay for it. In the absence of assurances that the quality of care and access to care will not decrease, we as a society will not take the chance. In other words, our default position in the face of uncertainty is to provide the service and increase the cost, and we are a nation faced with immense uncertainty about medicine.

Policy deals with populations of people: it deals with aggregates. Medical care deals with individuals and individual needs. We can set cost-containment policies, we can decrease DRG payments, we can set lower capitated amounts, we can build incentives that work. The Medicare PPS incentives regarding hospital admissions and the lengths of stay do work, and could work better if we wish to stay with them. However, attempts to do so on the aggregate are met with claims that individuals will suffer, and we as a nation (our political system and our basic morals and beliefs) focus on the needs of the individual. Our default position, therefore, is to provide more service when in doubt. Policy can develop incentives that work, but policy cannot make the medical necessity decisions for the individual patient. These reside with the doctor, the patient, the hospital, the nurse and the other providers.

Let me cite the example of hip fracture care and treatment under the Medicare PROs together with PPS (1). I cite this example because a number of individuals in Indiana were responsible for that study and its publication. Are the findings of that study an indictment of the failure of PPS? Or were the findings an indictment of the failure of clinical decision making? Or are they a broader failure of our medical care system? With fee for service payment, cost-based reimbursement and charge-based reimbursement, overutilization is the potential problem. With capitation and managed care, and PPOs, IPAs and Medicare DRGs, underutilization is the potential problem. In fact, the evidence to date shows very little difference in total expenditures between the two different payment mechanisms as they are currently structured.

The key conclusions for this Symposium that I draw from the preceding statements is that we cannot define or measure either over- or underutilization. We do not know why doctors and hospitals do what they do. We can describe the variations in medical practice, but are unable to make the normative decisions as to which variation is too little or too much. This is because, first, we cannot clearly define, let alone measure, quality of care. We have focused attention on the hospital, where we believe our support systems, our conditions of participation, our standards and our licensure laws will provide us with a minimal level of quality. We have not looked at the issue of quality of care in alternative settings and, as physicians, we have actively fought any attempts to do such a thing in a physician's office. Rarely have we examined the episode of illness and the outcome.

Second, we have not related the quality of a service to its value to the patient in either economic or noneconomic terms. Is a marginally positive improvement worth any price? What is unnecessary, and how do you define and measure it? In the area of cardiology, we have coronary artery bypass grafting, percutaneous coronary angioplasty, catheterization during the acute myocardial infarction, tissue plasminogen activator and a host of other technologies about which we have virtually no long-term outcome data, no value data, despite immense amounts of research.

Third, we have focused on a medical model and medical needs; we pay little attention to social needs. Again in the area of the hip fracture and the care of patients since the beginning of Medicare prospective payment policy, the group at Indiana University Medical Center showed that patients left the hospital "quicker and sicker." The number of rehabilitation services furnished decreased from pre-PPS levels, and once patients entered a nursing home, they stayed there. The key variable in those patients was absence of home support. The researchers could not identify any significant differences in the medical condition of the patient. They identified a significant difference in the social needs. The medical model that has guided us with its traditional, organizational and payment arrangements has not regarded home support as a key variable.

Fourth, we have a payment system and structure that are out of date. Medicare has a Part A and Part B. Blue Cross has Blue Cross and Blue Shield divisions, which, in some cases, are now merging. Our health care system is no longer divided into Parts A and B. It is no longer divided into

JACC Vol. 14, No. 3
September 1989:3A–6A

hospitals and doctors' offices. In the alternative care arena, we have few tools for measuring quality of care and outcome. In other words, we have immense gaps in our data and knowledge base. Where we do have information, it is frequently either not used or misused. The Blue Cross/Blue Shield Association together with the American College of Physicians generated a list of procedures that may be and frequently are unnecessary for the care of the patient. I have heard two things that are happening with that list. On the one hand, a few third parties want to translate that list directly to payment policy that was not intended or appropriate. On the other hand, physicians looked at the list, said that it was very interesting and proceeded to do exactly what they would have done before that list and the expert opinion attached to it. We simply do not use information or we misuse much of it when we do have it. I have cited coronary artery bypass surgery a number of times. Despite hundreds of millions of dollars spent in clinical trials and research for that procedure, information is still needed. How much information do we need to have and how can that information be used? There are flaws in the information base and in the decision making. The information is frequently inadequate for policy by third parties. I can structure financial incentives for populations in the aggregate. I can deal with the issues of the complex new cardiac pacemakers. In fact, however, these policies may not be implementable because they are not acceptable by clinicians who deal with individual patients and the clinicians complain through their professional organizations to the decision makers in Washington, D.C.

In summary, I have left for you what I believe is an extremely pessimistic, but challenging, outlook on how one can and should use medical information. Our health care system continues to be in chaos and continues to undergo dramatic changes that will continue for the foreseeable future. The interest in containing cost on an aggregate level remains, but we are not willing to reduce services in the absence of information to assure us that quality care will not be harmed. New technologies and capabilities are, in fact, allowing us to expand services both in and out of the hospital. We frequently have little information documenting the value of these new services to the many patients who receive them. In the face of uncertainty, the needs of the individual hold sway, and we will continue to err on the side of more rather than less. Our resources are finite, however, and the more we spend on the acute medical care model, the less will be available for other socially worthy needs such as housing, nutrition and long-term care and support.

My agenda includes four items for your consideration. First, we must totally restructure our delivery and payment models. Our current models are out of date. Second, we must better use the information we have available, better define the users and the targets of that information, better target messages to specific defined users and continue to develop more information related to quality of care for an entire episode of illness. Third, we must blend social needs with our traditional medical needs model in our information base and decision models. Fourth, we must learn much more about patient value systems, examine the utility of services to individual patients and build all of this into our model. If you are successful in developing information and decision models that result in patients receiving only medically necessary services, you will also be successful in promoting high quality care that is cost-conscious care. If you do this, you will make my job easier. I will, therefore, follow your progress and cheer you on.

References

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